

DEPARTMENT OF EMPLOYMENT
DIVISION OF WORKERS' SAFETY AND COMPENSATION
For Travel Starting 4/1/2006

REIMBURSEMENT VOUCHER

Case No: _____ SSN: _____ Date of Injury: _____
(Required)

Employee: _____ Phone Number: _____

Address: _____ ☐ Check here if new address.

City: _____ State: _____ Zip: _____

Claimant (if other than employee): _____

Address: _____

City: _____ State: _____ Zip: _____

In order to obtain medical care, I traveled from my home to the location of my health care provider. Under penalty of prosecution for false statement, I certify that the information I put on this form is true and correct.

Employee Signature: _____ Date: _____

Attach original receipts for all items claimed on this form. (Credit/Debit card receipts are not sufficient)

**Please attach verification of your trip (copy of doctor's bill or note from doctor verifying date and time of appointment). Medical bills will be reimbursed for the FIRST VISIT only. You must have the provider bill the Division directly for all subsequent bills.*

Description				If you are seeking reimbursement for a prescription item, please complete the section below	
From (City)	To (City)	Date	Miles	Name of Pharmacy/Drug	Date
Please submit the following:				Other Related Expenses (non-prescription supplies, over the counter, burial expenses not covered in funeral, etc)	
Date/Time You Left Home:				Expense	Amount Submitted
Date/Time of Appointment:					
Length of Appointment:					
Date/Time Discharged (from hospital):					
Date/Time You Arrived Home:					
Meals: (Maximum of \$6.00-breakfast \$9.00-lunch, \$14.25-dinner for a total of \$29.25) Date of Trip		Note: Breakfast is allowed if travel starts at or before 6:30 AM due to your appointment time. Dinner if travel extends beyond 7:00 PM Receipt Amount		ATTENTION CLAIMANT: Sign, date and mail all originals to: Workers' Safety and Compensation Division 1510 East Pershing Boulevard Cheyenne Business Center Cheyenne, WY 82002-0250	

Keep a copy of this document for your records

